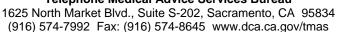


## Telephone Medical Advice Services Bureau





## NOTIFICATION OF CHANGE

## **CURRENT REGISTRANT INFORMATION: Contact Person: Business Name:** Address of Record: **Business Phone No.: Business Fax No. Mailing Address: Corporate Name: Corporate Address:** Name of Agent for Service **Type of Business:** □ Sole Proprietor □ Partnership □ Corporation ☐ Limited Liability Co. Name(s) of Owner(s) or Officers if a Corporation: I certify that the registrant information listed above is true and accurate and have included copies of all resolutions or other documents that substantiate the change(s). (Must be signed by the Owner(s) or Corporate Officers if a Corporation) Signature of Owner(s)/Officers Date Signature of Owner(s)/Officers Date Signature of Owner(s)/Officers Date Signature of Owner(s)/Officers Date